

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-63-001067

STATE FILE NUMBER

DO NOT WRITE  
ON THIS STUB

AMENDED

Registration District No. 128

Primary Registration District No. 2000

Registrar's No. 154A

FILED FEB 1 1963

1. PLACE OF DEATH a. COUNTY <u>Greene</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> COUNTY <u>Greene</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Springfield</u>		c. CITY OR TOWN <u>Walnut Grove</u>	
Length of stay in 1b <u>2 Days</u>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Burge-Protestant</u>		d. STREET ADDRESS (If outside, give location) <u>Route 2</u>	
Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>FLORA JANE BROOKS</u>		4. DATE OF DEATH Month <u>Jan.</u> Day <u>25</u> Year <u>1963</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>8-23-1889</u>
9. AGE (last birthday) <u>73</u>		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (City and state or country) <u>Seversville, Tenn.</u>		12. CITIZEN OF WHAT COUNTRY <u>USC</u>	
13a. FATHER'S NAME <u>James Gilbert Smith</u>		13b. MOTHER'S MAIDEN NAME <u>Julia Adeline Ketner</u>	
14. NAME OF HUSBAND OR WIFE <u>William E. Brooks</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of) <u>no</u>	
16. SOCIAL SECURITY NO.		17. INFORMANT <u>Winnie Goff, Strafford, Mo.</u>	
18. CAUSE OF DEATH (Enter only one cause per PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Uterine Sclerotic Heart Disease</u>		INTERVAL BETWEEN ONSET AND DEATH	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.		DUE TO (b) _____	
DUE TO (c) _____		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)	
20c. TIME OF INJURY Hour _____ a.m. _____ p.m. Month, Day, Year _____	20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION COUNTY STATE	
21. I attended the deceased from <u>Oct 1956</u> to <u>1-25-63</u> and last saw her alive on <u>1-25-63</u> Death occurred at <u>6:40 PM</u> on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Deceased or title) <u>Max Fitch M.D.</u>		22b. ADDRESS <u>1715 Boonville Springfield Mo.</u>	
22c. DATE SIGNED <u>2-4-63</u>		(State)	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>Jan. 27, 1963</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Rose Hill Cemetery, Walnut Grove, Mo.</u>	
24. FUNERAL DIRECTOR <u>Brim-Daniel, Inc. Walnut Grove, Mo.</u>		25. DATE RECD. BY LOCAL REG. <u>2-7-63</u>	
26. REGISTRAR'S SIGNATURE <u>Effie E. McElvaine</u>			

(Licensed Embalmer's Statement on Reverse Side)

MAX FITCH, M.D.  
USE BLACK INK  
OR  
TYPEWRITER RIBBON

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

ITEM NO.

DATE AMENDED

VS 300  
Rev. 4/59  
6397  
20390  
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4 1  
5 2  
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7 1  
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9 4200  
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12 1-0  
13

DOCUMENT

BY AFFIDAVIT OF

MEDICAL CERTIFICATION

FEB 13 1963

1-20-63

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed \_\_\_\_\_  
*Joseph H. Daniel*

Licensed Embalmer No. 4702

P. O. Address Ashe Grove

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.